

Emergency Information Form for Children With Special Needs



American Academy
of Pediatrics



Date form
completed
By Whom

Revised
Revised

Initials
Initials

Name:		Birth date:	Nickname:
Home Address:		Home/Work Phone:	
Parent/Guardian:	Emergency Contact Names & Relationship:		
Signature/Consent*:			
Primary Language:	Phone Number(s):		
Physicians:			
Primary care physician:		Emergency Phone:	
		Fax:	
Current Specialty physician: Specialty:		Emergency Phone:	
		Fax:	
Current Specialty physician: Specialty:		Emergency Phone:	
		Fax:	
Anticipated Primary ED:		Pharmacy:	
Anticipated Tertiary Care Center:			

Diagnoses/Past Procedures/Physical Exam:	
1 .	Baseline physical findings:
2.	
3.	Baseline vital signs:
4.	
Synopsis:	
	Baseline neurological status:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:

Significant baseline ancillary findings (lab, x-ray, ECG):

1.

2.

3.

4.

5.

6.

Prostheses/Appliances/Advanced Technology Devices:

Management Data:**Allergies: Medications/Foods to be avoided****and why:**

1.

2.

3.

Procedures to be avoided**and why:**

1.

2.

3.

Immunizations**Dates**

DPT

OPV

MMR

HIB

Dates

Hep B

Varicella

TB status

Other

Antibiotic prophylaxis:

Indication:

Medication and dose:

Common Presenting Problems/Findings With Specific Suggested Managements

Problem

Suggested Diagnostic Studies

Treatment Considerations

Comments on child, family, or other specific medical issues:**Physician/Provider Signature:****Print Name:**